August 4, 2011

Re: Health Net Life Insurance Company
State Tracking Number(s): PF-2011-01506, PF-2011-01507

Unless otherwise stated as referring to both filings, the questions below refer to PF-2011-01506 only.

1. **Scope of products reviewed by the Department** (both filings)**.** The Department is specifically concerned with rate increases on medical coverage only, excluding riders for ancillary benefits such as vision and dental. Be sure all increases shown in the actuarial memoranda and accompanying exhibits (e.g., "The requested overall rate increase is 11.9%") indicate the effect on rates for medical coverage only.

   Response: The overall requested rate increase of 11.9% only applies to the medical coverage of the benefit plans.

2. **Changes to Benefits** (both filings)**.** Describe in detail changes to benefits over the past 12 months, if any, indicating which of these are mandated, and the rate impact of each of those changes.

   Response: All benefit changes in the past 12 months have been mandated due to healthcare reform. Rate increases due to the mandated benefit changes were effective 12/31/2010 for all plans and for all insureds. The following information comes from PF-2010-01969 and PF-2010-01968

   The impact on the following four benefit changes had a 1% impact on the rates for both grandfathered and non-grandfathered plans. In order to minimize changes in the rates for insureds in both grandfathered and non-grandfathered plans, we have not had a rate increase for these benefit changes.

   - Dependents will be covered up to age 26.
   - Removal of lifetime limits.
   - Removal of annual limits on essential benefits.
   - Prohibition of recission.

   The next benefit change due to healthcare reform is the guaranteed issue for applicants 18 years and under with preexisting conditions.

Impact of Guaranteed Issue For Applicants 18 Years and Under With Preexisting Conditions			
Plan	Average Rate Change	Minimum Rate Change	Maximum Rate Change
Optimum Advantage HSA 2500	0.8%	0.0%	5.6%
Optimum Advantage HSA 4500	0.5%	0.0%	5.8%
NetFirst – Comb Rx *	0.0%	0.0%	0.0%
NetFirst – Generic Only *	0.0%	0.0%	0.0%
ValueNet *	0.0%	0.0%	0.0%
BalanceNet	0.5%	0.0%	5.4%
Premier 40	0.1%	0.0%	2.2%
Value Basic 40	0.3%	0.0%	2.4%
SimpleChoice 25	0.5%	0.0%	5.5%
SimpleChoice 35	0.7%	0.0%	5.3%
SimpleChoice 50	0.6%	0.0%	5.4%
SimpleValue 50 – Combo Rx *	0.0%	0.0%	0.0%
SimpleValue 50 – Generic Rx *	0.0%	0.0%	0.0%

Impact of Guaranteed Issue For Applicants 18 Years and Under With Preexisting Conditions			
Plan	Average Rate Change	Minimum Rate Change	Maximum Rate Change
Salud PPO 15 NG	0.3%	0.0%	4.9%
Salud PPO 15/25% NG	0.3%	0.0%	5.4%
Salud PPO 25 NG	0.4%	0.0%	5.3%

* - These plans are subscriber only plans which requires all applicants to be on their own policy including dependent children.

The last benefit change due to healthcare reform is covering preventive services at 100%.

Preventive Health Services Covered at 100%			
Plan	Average Rate Change	Minimum Rate Change	Maximum Rate Change
Optimum Advantage HSA 2500	5.4%	1.6%	17.3%
Optimum Advantage HSA 4500	7.1%	2.2%	24.1%
NetFirst – Comb Rx	3.3%	0.8%	9.9%
NetFirst – Generic Only	3.7%	0.9%	10.7%
ValueNet	6.8%	2.0%	22.6%
BalanceNet	5.4%	0.8%	10.3%
Premier 40	1.5%	0.7%	4.9%
Value Basic 40	2.8%	1.2%	12.3%
SimpleChoice 25	2.7%	0.8%	8.2%
SimpleChoice 35	3.1%	0.9%	11.5%
SimpleChoice 50	3.7%	1.0%	16.1%
SimpleValue 50 – Combo Rx	3.0%	0.9%	13.1%
SimpleValue 50 – Generic Rx	3.2%	1.0%	13.6%

Preventive Health Services Covered at 100%			
Plan	Average Rate Change	Minimum Rate Change	Maximum Rate Change
Salud PPO 15 NG	3.0%	0.2%	11.9%
Salud PPO 15/25% NG	4.8%	2.0%	14.0%
Salud PPO 25 NG	4.6%	1.3%	16.2%

3. **Rate Increase History** (both filings). Describe any material changes to benefits at the time of rate increase since 2007 to the products listed. Quantify the impact on rates of the benefit changes.

Response: For 1/1/2009 the following pharmacy benefit changes occurred without a change in rates. Based on experience, the value of the benefit change is as follows:

Plan	Old Rx Benefit Generic/Brand/Non-Formulary Deductible	New Rx Benefit	Rate Change
PPO 20	$10/$25	$5/$25/$50 - $500 Brand	-2.9%
Premier 20	$10/$25	$5/$25/$50 - $500 Brand	-2.9%
Premier 30	$10/$25	$5/$25/$50 - $500 Brand	-2.9%
Premier 40	$10/$25	$5/$25/$50 - $500 Brand	-2.9%
Value 750	$15/$35/$50 - $100 Ded*	$5/$35/$50 - $500 Brand	-1.4%
Value 25	$15/$35/$50 - $100 Ded*	$5/$35/$50 - $500 Brand	-1.4%
Value 30	$15/$35/$50 - $100 Ded*	$5/$35/$50 - $500 Brand	-1.4%
Value 400	$15/$35/$50 - $100 Ded*	$5/$35/$50 - $500 Brand	-1.4%
Value Basic 2500	$15/$35/$50 - $100 Ded*	$5/$35/$50 - $500 Brand	-1.4%
Simple Choice 15	$5/$35/$50 - $250 Brand	$5/$35/$50 - $500 Brand	-0.9%
Simple Choice 15 (CSFA)	$5/$35/$50 - $250 Brand	$5/$35/$50 - $500 Brand	-0.9%
Simple Choice 25	$5/$35/$50 - $250 Brand	$5/$35/$50 - $500 Brand	-0.9%
Simple Choice 35	$5/$35/$50 - $250 Brand	$5/$35/$50 - $500 Brand	-0.9%
Simple Choice 40	$5/$35/$50 - $250 Brand	$5/$35/$50 - $500 Brand	-0.9%
Simple Choice 50	$5/$35/$50 - $250 Brand	$5/$35/$50 - $500 Brand	-0.9%

* - Applies to both generic and brand.

The table below shows the history of what the rate increases would be without any benefit changes from 2007 to the present.

Plan	Proposed 10/2011	History of Rate Increases 10/10	7/09	1/09	7/08	7/07	1/07
PPO $20 Copay	10.0%	16.2%	24.7%	2.9%	25.2%	19.7%	--
Premier $20 Copay	10.0%	16.2%	24.7%	2.9%	25.2%	19.7%	--
Premier $30 Copay	10.0%	16.2%	10.0%	2.9%	15.0%	10.0%	--
Premier $40 Copay	10.0%	16.2%	24.7%	2.9%	25.2%	10.0%	--
Value $25	10.0%	21.2%	24.7%	1.4%	25.2%	10.0%	--
Value $30	17.0%	21.2%	20.0%	1.4%	25.2%	10.0%	--
Value $400	17.0%	20.2%	20.0%	1.4%	15.0%	19.7%	--
Value $750	10.0%	16.2%	24.7%	1.4%	25.2%	19.7%	--
Value $500	0.0%	17.2%	12.0%	--	25.2%	10.0%	--
Value Basic $1,000	10.0%	16.2%	24.7%	--	25.2%	19.7%	--
Value Basic $2,500	18.0%	21.2%	24.7%	1.4%	25.2%	19.7%	--
Value Basic $35	0.0%	9.2%	10.0%	--	15.0%	19.7%	--
Value Basic $40	10.0%	10.2%	20.0%	--	25.2%	19.7%	--
Value Basic $500	0.0%	10.2%	24.7%	--	15.0%	10.0%	--
NetSaver $1,500	18.0%	21.2%	34.0%	--	10.0%	0.0%	--
Value Choice $1,500	18.0%	21.2%	34.0%	--	10.0%	0.0%	--
CSFA Value Choice 1500	18.0%	21.2%	34.0%	--	10.0%	15.3%	--
Simple Choice HSA	17.0%	11.2%	19.0%	--	10.0%	2.7%	--
Smart Choice HSA	10.0%	16.2%	29.0%	--	10.0%	-1.1%	--
Simple Choice 15	15.0%	17.2%	19.0%	0.9%	35.0%	11.9%	--
CSFA Simple Choice 15	15.0%	17.2%	19.0%	0.9%	35.0%	25.0%	--
Simple Choice 25	15.0%	13.2%	19.0%	0.9%	30.0%	12.2%	--
Simple Choice 35	5.0%	13.2%	19.0%	0.9%	30.0%	12.2%	--
Simple Choice 40	18.0%	21.2%	34.0%	0.9%	35.0%	12.2%	--
Simple Choice 50	5.0%	13.2%	19.0%	0.9%	30.0%	12.1%	--
Simple Value 30 (Generic & Combo Rx)	18.0%	21.2%	24.0%	--	35.0%	12.6%	19.0%
Simple Value 40 (Generic & Combo Rx)	18.0%	21.2%	24.0%	--	35.0%	12.6%	19.0%
Simple Value 50 (Generic & Combo Rx)	18.0%	21.2%	19.0%	--	30.0%	12.5%	19.0%
First Choice	5.0%	11.2%	29.0%	--	30.0%	12.0%	--
BalanceNet	18.0%	11.2%	--	--	--	--	--
NetFirst (Generic & Combo Rx)	18.0%	17.2%	--	--	--	--	--
Opt Advantage HSA 2500	15.0%	25.2%	--	--	--	--	--
Opt Advantage HSA 4500	0.0%	16.2%	--	--	--	--	--
ValueNet	15.0%	11.2%	--	--	--	--	--
Total	11.9%	17.5%	23.2%	0.4%	25.9%	13.2%	19%*

Note: The rate increase effective 12/31/2010 due to mandated healthcare reform changes had an overall 0.9% change in the rates for all plans.

Plan	Requested 10/2011	History of Rate Increases 10/10	7/09	7/08	7/07
Salud PPO 15	10.0%	21.2%	19.0%	15.0%	0%
Salud PPO 15/25%	10.0%	21.2%	19.0%	15.0%	0%
Salud PPO 25	10.0%	21.2%	19.0%	15.0%	0%

4. **Intent to File for Future Rate Increases.** When does the company intend to file for its next round of rate increases for individual policies?

   Response: The next rate increase is intended to be filed for an effective date of October 1, 2012.

5. **Filed Rate Changes.** For each product, provide the average, minimum and maximum tabular rate changes proposed:
   a. For the current filings

   There are no changes in the age slope and no changes in the relativities between the rating regions. Therefore, all rates within a particular plan are receiving the same rate increase. See the table in #3 for the proposed rate increase for each plan.

   b. For all filings cumulatively during the twelve-month period ending with the next renewal date, according to the policies' anniversary dates.

   Response: The only changes in the rates during the past 12 months have been due to benefit changes for PPACA and going from gender based rates to gender neutral were effective 12/31/2010. Those changes applied to all insureds with a 12/31/2010 effective date. There should be no insureds receiving a change in the 10/1/2011 rates due to mandated benefit changes for PPACA and going from gender based rates to gender neutral rates.

6. **Rate Caps.** Describe the action of rate caps, if any.

   Response: There are no rate caps.

7. **Development of Annual Rate Increase Percentage**

   a. Provide membership, earned premium and incurred claims data for general product groupings for CY 2008, 2009 and 2010, if available.

   Response: See attached file – "HN-CA IFP PPO CDI Request" – Exhibit 7a

   b. You have stated that the risk margin of 2% is "consistent with guidance from the CDI in 2010." Please attach the guidance to which you are referring.

   Response: The guidance comes from the rate review that David Axene's company did of Health Net's rate increase effective 10/1/2010.

   "HealthNet's underlying inflationary trend value is 11.6% (i.e., 1.0896 x 1.024 = 1.1158), very close to our underlying assumption of 11.5%. They have added a 2% trend miss margin as we had done in the initial Anthem Blue Cross rate review. This underlying assumption was adjusted for benefit plan design (i.e., deductible leveraging) resulting in trend

assumptions that ranged from 13.8% to 16.5%. Table 9 shows no medical deterioration and wear-off of selection."

"It is our professional opinion that the trend assumptions presented in this rate filing are reasonable in light of the latest information we have and are using. The Department has noted that multiple carriers have been reported in the press as seeing their trends reduce in recent months. We have not yet observed this as a statewide pattern here in California and stand by our trend assumptions as being reasonable. If in fact trend is reducing, future rate increases will be lower as reported claims costs in future rate filings will be lower."

"HealthNet's deductible leveraging factors are consistent with information we would develop from our firm's proprietary claims distribution information."

c. Revise Table 5 to exclude revenue and claims from the dental and vision riders. Submit the revised table in Excel.

Response: The table below is the revised version of Table 5 (PF-2011-01507) that excludes revenue and claims from the dental and vision riders.

Experience Period Beginning Ending	 1/1/2010 12/31/2010
Current Membership - 5/1/2011	33,782
Member Months for the Experience Period	455,227
Revenue	$86,435,868
Total Claims	$75,251,890
Loss Ratio	87.1%
Based on 2010 Membership	
Adjusted Revenue (Using Rates as of 12/31/10)	$102,094,019
Trended Claims	$93,747,810
Requested Rate Increase	12.6%
Revenue Based Upon Rate Increase	$114,908,629
Expected Statutory Loss Ratio	81.6%
Weighted by Current Membership	
Adjusted Revenue (Using Rates as of 12/31/10)	$83,522,446
Trended Claims	$74,893,038
Requested Rate Increase	11.9%
Revenue Based Upon Rate Increase	$93,428,171
Expected Statutory Loss Ratio	80.2%

The table below is the revised version of Table 3 (PF-2011-01507) that excludes revenue and claims from the dental and vision riders.

Experience Period Beginning Ending	 1/1/2010 12/31/2010
Current Membership - 5/1/2011	612
Member Months for the Experience Period	9,411
Revenue	$1,567,495
Total Claims	$1,214,160
Loss Ratio	77.5%
Based on 2010 Membership	
Adjusted Revenue (Using Rates as of 12/31/10)	$1,849,518
Trended Claims	$1,502,254
Requested Rate Increase	10.0%
Revenue Based Upon Rate Increase	$2,034,469
Expected Statutory Loss Ratio	73.8%
Weighted by Current Membership	
Adjusted Revenue (Using Rates as of 12/31/10)	$1,447,071
Trended Claims	$1,219,344
Requested Rate Increase	10.0%
Revenue Based Upon Rate Increase	$1,591,778
Expected Statutory Loss Ratio	76.6%

d. Appendix C, from the memorandum of the independent actuary: derivation of step 6 is unclear. Are these monthly figures? Why is G&A shown only for dental and vision? Please submit this exhibit in Excel.

Response: The purpose of Step 6 is to show that the overall average rate increase is being weighted by current membership rather than the membership in the experience period. As membership in plans that are closed continue to decrease therefore the rate increases that are being applied to those plans have a lower impact on the overall average rate increase. See 8b for additional information.

These figures are not monthly. The exhibit also shows G&A under the Dental & Vision column, we believe that is should be shown under the HCC Amount column. This changed has been made for the attached exhibit.

Response: See attached file – "HN-CA IFP PPO CDI Request" – Exhibit 7d

e. Loss ratios are expected to increase above target in closed blocks due to lengthening duration. These higher loss ratios are of course offset by lower expected loss ratios for new business. For the rating period, show the duration adjustment to the target loss ratio for the closed blocks. Provide documentation for the duration adjustments.

Response: Due to limited experience, durational adjustments factors were developed by outside consultants for the rate change effective 10/1/2010. The duration adjustment for the closed blocks is 1.08.

Response: See attached file – "HN-CA IFP PPO CDI Request" – Exhibit 7e

f. **PF-2011-01507**: The independent actuary has noted that the experience on this form is not credible for use in determining a federal MLR. Given that the experience is not considered 100% credible, it is to be assumed that the rates were developed on the basis of one or more other credible data sources.
   i. Describe the source and the reasons for choosing the credible data sources.
   ii. Show the development of the requested rate increases based on those credible data sources.

Response: The Salud IFP PPO rates for PF-2011-01507 were developed in conjunction with our standard IFP PPO rates for PF-2011-01506. Due to the lack of credibility for the Salud IFP PPO plans, the starting point for the rate increase was the projected trend of 14.2%. In light of the rate increase of 21.2% on 10/1/2010 for the Salud plans versus an overall average rate of 17.7% for the other IFP PPO plans, we decided to reduce the rate increase to 10%.

8. Annual Rate (from the memorandum of the independent actuary**)**:

a. The independent actuary has stated, under item 12 of his report, that "the increase for each benefit plan is also identical." However, the HN-CA IFP PPO Annual Rates.pdf file that you submitted on SERFF shows differing levels of increase. For example, pg. 31, Individual PPO Plans, Rating Region 1, Optimum Advantage HSA 4,500 NG shows 0% increase whereas HSA 2,500 NG and BalanceNet NG show increases well over 10%. Explain the discrepancy.

Response: The intention of the actuary was to indicate that there were no changes in the slope of the rates and there were no adjustments to the regional rating factors. As a result, within a benefit plan, all rates were adjusted by the same percentage.

b. Provide an Excel spreadsheet showing the derivation of the overall average rate increase from the tables in HN-CA IFP PPO Annual Rates.pdf.

Response: See attached file – "HN-CA IFP PPO CDI Request" – Exhibit 8b

9. Enrollment summary (both filings)**.** Provide total monthly member enrollment of each individual product (including policies not covered by these filings) from January 2007 on. Indicate whether the product is open or closed. Show separately enrollment for conversion policies and for policies under the supervision of DMHC. Show historical sales and lapses.

Response: See attached file – "HN-CA IFP PPO CDI Request" – Exhibits 9

10. **Underwriting Loads.** Show the changes to average underwriting load over the past two years.

    Response: See attached file – "HN-CA IFP PPO CDI Request" – Exhibit 10

11. **Impact of Benefit and Area Definition Change** (both filings)**.** Are the rate increases described in Table 7 independent of changes in benefit or rating region definition? If not, please revise accordingly.

    Response: There were no changes in the slope of the rates and there were no adjustments to the regional rating factors.

12. **Co-pays** (both filings)**.** Indicate whether office co-pays are included in the out-of-pocket maximum

    Response: Office visit co-pays are included in the out-of-pocket maximum.

13. **Medical Loss Ratio per PPACA** (both filings)**.** The Department requires a Medical Loss Ratio (MLR) exhibit according to the guidance issued by the Department of Health and Human Services (HHS) on 11/18/2010. The MLR exhibit should show *by month* actual 2010 and 2011 experience and the prospective experience in 2011 and 2012 of the market segment relevant to plans being filed (i.e., *all individual plans* regulated by the Department, including those not included in the current filings). Actual experience used should be most recent available with credible runout, preferably incurred or earned at least through March 2011. Experience should show enrollment, incurred claims and earned premium. Breakouts should also be by open block and closed block, and for conversions. All individual plans will be aggregated for the purposes of MLR calculation, and the MLR will be calculated in accordance with the HHS regulation.

    Response: The table below shows the calculation of the MLR.
    See attached file – "HN-CA IFP PPO CDI Request" – Exhibit 13

Projected Federal Loss Ratio for Calendar Year 2011 for all CDI Individual Products	
(a) Statutory Loss Ratio	90.94%
(b) Expected Pre-Tax Profit	-11.00%
(c) Federal Tax Rate for Company	32.60%
(d) Expected Federal tax (b) x (c)	-3.59%
(e) Premium tax	2.35%
(f) Preliminary Federal Loss Ratio [(a) /((1 – (d) – (e))]	89.83%
(g) Adjustment for Credibility of 38,913 life years	1.38%
(h) Deductible Adjustment Factor	1.12
(i) Final Federal Loss Ratio [(f) + (g) x (h)]	91.37%

14. **Changes in enrollee cost-sharing (California Rate Filing Form, item 21)** (both filings)**.** You have stated that "under PPACA, Preventive Care benefits were exempted from cost-sharing . . . [per] PF-2010-10969 . . . the percentage change ranges from 1.5% to 7.1%." For both filings, what is the average such change, based on the membership affected by the current rate filing?

    Response: For current membership, the average rate change due to preventive care benefits being covered at 100% for both filings is 5.85%.

15. **Comparison of Claims Cost** (California Rate Filing Form, Appendix A):
    a. What is meant by an "open" plan grouping? Does this refer to all plans now actively marketed?

    Response: The "Open" plan grouping refers to the plans that are currently being marketed.

    b. For each plan grouping, and for all groupings together, show the average projected and 12-month costs and annual rates of change.

    Response: See attached file – "HN-CA IFP PPO CDI Request" – Exhibit 15

16. **Secular Trend Detail**
    a. Consistent with the exhibits for projected trend in the California Rate Filing Form, for CY2009 to 2010 and CY2008 to 2009 show pmpm cost and utilization breakout by aggregate benefit category, i.e. hospital inpatient, hospital outpatient (including emergency room), etc. (SB1163, SEC. 7. 10181.3(b)(18)).

    Response: See attached file – "HN-CA IFP PPO CDI Request" – Exhibit 16a

    b. State the degree of credibility of experience data used in estimating medical trend inflation.

    Response: We used actual experience to validate the trend factors used in this rate filing. The trend factors were developed based on the assessment of the actual contractual changes by provider.

    c. For CY2010 to 2011, further allocate cost and /or utilization trends by pure inflation and change in mix of services

    Response: See attached file – "HN-CA IFP PPO CDI Request" – Exhibit 16c

    The actuarial memorandum states that the overall utilization factor is 2.47%, whereas, the exhibit for 16c shows the overall utilization factor is 2.8%. The difference is that the utilization factor of 2.47% has been weighted based on all of our Individual PPO products,

whereas, the utilization factor of 2.8% has been weighted based on the experience data for the IFP PPO plans that are a part of this rate filing.

17. Contractual Increases

a. Provide an exhibit showing the contractual increases for 2011 by rating area for inpatient and outpatient services. Show the weights assigned to each increase.

Response: See attached file – "HN-CA IFP PPO CDI Request" – Exhibit 17a

b. For each type of inpatient service (medical, surgical etc) in 2009 and 2010, show days per member per year, cost per patient per day, and the associated trends, including the breakout between trend in unit cost and utilization / mix. Calculate the total mix shift.

Response: See attached file – "HN-CA IFP PPO CDI Request" – Exhibit 17b & 17c

c. For each type of outpatient service (ER, surgical etc) in 2009 and 2010, show days per member per year, cost per patient per day, and the associated trends, including the breakout between trend in unit cost and utilization / mix. Calculate the total mix shift.

Response: See attached file – "HN-CA IFP PPO CDI Request" – Exhibit 17b & 17c

d. What actions has the company taken in the interest of policyholders to ensure the lowest negotiated prices from hospitals and out-patient facilities?

Response: Health Net considers making health care affordable as our primary strategic imperative. Achieving the lowest negotiated prices from hospitals and outpatient facilities are top priorities for Health Net in achieving this imperative.

We have dedicated and experienced teams that negotiate prices with hospitals. They use existing Health Net data, data from OSHPD and other market information to secure competitive pricing. The goal is two-fold: a) achieve a lower unit-cost and b) develop multi-year agreements to achieve sustainable trends. These teams are empowered to terminate hospitals if terms are not acceptable as long as we assure orderly transition of care and our networks continue to meet regulatory and market requirements.

While these teams are highly capable, they are challenged during negotiations by a combination of increasing bargaining power as major hospital systems consolidate and the fact that hospitals increasingly seek higher reimbursements from Commercial business as a means to subsidize their losses on the Medicare and Medicaid programs (commonly known as the "Cost Shift"). Our additional strategic actions during negotiations are aligned around these two environmental factors:

The Cost Shift:
The Cost Shift is a primary cost driver for the Commercial market as delivery systems raise charges for Commercial membership as a means to subsidize their losses under the Medicare and Medicaid programs. This model fundamentally does not make long-term economic sense

for a delivery system due to the fact that it has diminishing returns as commercial members drop coverage, retreat to high deductible plans (increasing debt collection issues) or move to competing delivery system models.

We have taken this message to delivery systems as a value proposition in terms of a new economic model. Under this model, we illustrate the need for providers to retain Commercial share, which requires a competitive cost model. Concurrently we work with providers on risk management solutions for Medicare and Medicaid so those programs can achieve improved financial performance.

18. Drivers of Medical Trend

a. Describe the significant economic and medical developments that have been driving Health Net's *in-patient* price inflation in the recent past. For each of these developments, explain at what level it should reasonably be expected to continue in future, and why.
b. Describe the significant economic and medical developments that have been driving Health Net's *out-patient* price inflation in the recent past. For each of these developments, explain at what level it should reasonably be expected to continue in future, and why.

Response for a & b: We are not able to calculate the impact of the current economy on medical cost trends. Our forecasts are based on sound actuarial models that incorporate prior claims experience and both prior and project unit cost increases.

As to the impact of medical developments, there are three primary drivers of in-both patient and outpatient price inflation in the recent past. They are:

The Cost Shift: As covered in Answer 17, delivery systems raise charges for Commercial membership as a means to subsidize their losses under the Medicare and Medicaid programs. While Health Net has made concerted efforts to raise awareness around this issue and its associated diminishing returns (also covered in Answer 17), government programs are in budgetary crisis and regularly look to decrease Medicare and Medicaid reimbursement as a means for savings. These are also the two largest growth populations for delivery systems: Medicare (as a result of an aging population) and Medicaid (as a result of health care reform and the current economic climate). We believe this phenomenon will persist at levels consistent with the recent past unless there is reform that specifically addresses the cost-shift problem.

Delivery System Cost Inflators Hospitals in California cite several contributing factors to their overall need for increased costs, including the rising number of uninsured members, the continuing challenging economy (bad debts, investment losses, etc,) and a need to keep pace with technological innovation to compete for provider referrals. There are other legacy cost issues that are not as inflationary but keep the base cost high, including high labor costs and seismic retrofitting. The economy is not expected to rebound in the near future, these contributors are expected to persist.

c. Describe the significant economic and medical developments that have been driving Health Net members' increasing utilization in the recent past. For each of these developments, explain at what level it should reasonably be expected to continue in future, and why.

Response: The primary economic and medical drivers that are driving increased utilization in the recent past have been the advancement of medical technology, the aging population and overall population health. Aging and population health are demographic factors that have been increasing at an accelerated rate.

It is our expectation that the aging factor will increase over time due to fundamental demographic shifts as more and more Baby Boomers enter their later life stages. Combined with the widely documented increases in chronic conditions like diabetes and obesity, we expect population health to trend consistent with the recent past, or moderately increase.

The prevalence of disease and the advancement of technology have a compounding impact on utilization increases. For example, with increasing obesity, there is more arthritis of the weightbearing joints (hips and knees). Advancing technology reduces the morbidity of joint replacement procedures, which, due to the invasiveness, lowered pain thresholds and shortened rehabilitation periods, now become more attractive and utilized options for a growing population. Obesity and diabetes (and associated lifestyle behaviors such as inactivity and poor diet) also lead to co-morbidities such as cardiovascular diseases, resulting in an increase in surgeries such as coronary artery bypass surgery (CABG) and an increase in diagnostic testing. This testing can include invasive studies like angiography, which, in turn, can lead to higher therapeutic cost through the placement of stents and drug-eluting stents, as well as higher medical management and drug expense, and the added costs of side effects, complexity and risks of polypharmacy.

These factors have some unpredictable variance, such as what happened with H1N1, which contributed to our utilization factors in the past. Clearly, all contributing factors are unknown for future projections. Ultimately rate reform under the Accountable Care Act will impact these inflationary factors as rate bands collapse, prohibition of pre-existing condition exclusions and other factors will attract older and sicker populations to the Commercial insurance pool.

d. Describe whether and how the independent actuary has independently observed these medical trends and whether it includes them in its pricing model.

Response: The independent actuary received the attached file "HN-CA IFP Reports 09 – Historical Trend Analysis (Ingx) 2011-04-06 v2.zip". This was used by the independent actuary determine the reasonableness of the trend factors in our pricing model.

19. Co-pays (both filings)**.** Indicate whether office co-pays are included in the out-of-pocket maximum.

Response: See response to #12

20. Lifetime Loss Ratios (both filings)**.** Provide and justify the key assumptions used to derive lifetime loss ratio (LLR) estimates for the various products. In particular, show how the LLR projections are based on the durational factors in item #7e above.

Response: The lifetime loss ratio model was developed by an independent actuary for the rate increase effective 10/1/2010. The model was then further reviewed by David Axene's Company and based on their report they found no material issues with the model. The model was then updated to include historical data through calendar year 2010.

The following is a list of the key Assumptions used to derive the lifetime loss ratio.

1. Claims trend (excluding duration) for 2011 is 14.3%
2. Claims trend (excluding duration) for 2012-2026 is 8%. Please note that we expect future claims trends to be greater than 8% and we intend to adjust our rates according to actual trends.
3. New sales are only through 2011.
4. Expected rate increases for 2012-2026 is 8% for all plans.
5. Discount rate is 5%.
6. The monthly lapse rate varies by the experience of the plan and the duration of the plan from 1.9% to 5.9%. The lapse rates were developed from actual experience. The table below shows the annual lapse rate for closed and open plans.

Duration Year	Annual Lapse Rate for Closed Plans	Annual Lapse Rate for Open Plans
0	37.5%	37.5%
1	36.0%	33.0%
2	33.0%	28.0%
3	31.5%	26.5%
4	31.0%	26.0%
5	30.5%	25.5%
6	30.0%	25.0%
7	29.5%	25.0%
8	29.0%	25.0%
9	29.0%	25.0%
10	29.0%	25.0%
11+	29.0%	25.0%

7. The durational factors used in the lifetime loss ratio model were developed by an independent actuary. Based on the duration of each plan, an overall durational factor was developed for the lifetime of each plan. The table below shows the durational factors used to develop the overall durational factor. The durational factors in the table below for duration years 1-6 are the same as the durational factors found in the Milliman Guidelines for Commercial Rating Structures.

Duration Year	Duration Factors HSA Plans	All Other
0	0.475	0.600
1	0.700	0.700
2	0.850	0.850
3	0.950	0.950
4	1.000	1.000
5	1.050	1.050
6	1.100	1.100
7	1.100	1.100
8	1.100	1.100
9	1.100	1.100
10	1.100	1.100
11+	1.100	1.100

8. The seasonality factors used in the lifetime loss ratio model were developed by an independent actuary. The table below shows the seasonality factors used in developing the lifetime loss ratio.

Month	Non-CDHP	CDHP
Jan	0.94	0.72
Feb	0.99	0.84
Mar	0.99	0.88
Apr	0.99	0.89
May	1.00	0.96
Jun	0.99	1.01
Jul	0.99	1.00
Aug	1.00	1.01
Sep	1.02	1.09
Oct	1.01	1.10
Nov	1.05	1.19
Dec	1.04	1.30

21. Additional information required per Guidance 1163:2. Provide the following per Section A of the Guidance: the nature and amount of transactions between the filing insurer and any affiliates over the prior three years.

Response: The Company entered into administrative services agreements ("ASA") with affiliates in order to receive office space and various administrative, management, and support services. The Company does nevertheless exercise ultimate control over its assets and operations and retains the ultimate authority and responsibility regarding its powers, duties, and responsibilities. For 2010, 2009, and 2008, the Company was charged $191,290,548, $185,851,441, and $201,923,097 respectively, for these services provided by affiliates and the Company charged $1,340,854, $1,709,928, and $1,858,385, respectively, for services it provided to affiliates.

Effective January 1, 2003, the Company and HN of CA entered into a premium administration agreement ("the Agreement") in order to mitigate selection risks, when jointly marketing their products. In accordance with the Agreement, risk adjustment allocations are used to allocate aggregate premiums to more equitably correspond with the benefit costs reported by each legal entity. For the years ended December 31, 2010, 2009 and 2008, HN of CA allocated premiums totaling $39,889,034, $14,872,250, and $17,800,445, respectively, to the Company under the terms of this Agreement.

The Company paid an ordinary cash dividend of $35,000,000 to its Parent Company on October 23, 2009 (none in 2010 or 2008). In addition, the Company paid an aggregate dividend of $94,000,000 through August 1, 2011.

Affiliate Reinsurance—The Company is a party to an affiliate quota share reinsurance agreement with Health Net Life Reinsurance Company to cede 50% of the California-based PPO health business and Medicare business. The following is a financial summary of the ceded amounts under this agreement:

	2010	2009	2008
For the years ended December 31:			
Premiums	$797,751,000	$757,885,000	$813,080,000
Benefits	676,464,000	649,589,000	692,992,000
Commissions and expense allowances	113,619,000	108,118,000	117,396,000
As of December 31:			
Due premium	16,383,000	19,691,000	23,593,000
(Payable to) receivable from reinsurer	(14,353,000)	2,650,000	(7,259,000)
Health care receivable and receivable relating to uninsured plans	18,401,000	187,000	72,643,000
Accrued retrospective premium			964,000
Unearned premium reserves	218,000	106,000	1,317,000
Claims payable	61,803,000	61,460,000	88,979,000
Payable for experience rating refunds	5,370,000	12,754,000	1,183,000
Payable to reinsurer (not currently due)	33,855,000	55,650,000	(4,184,000)
Claims adjustment expense liability	1,248,000	1,208,000	1,537,000

Since Health Net Life Reinsurance Company is considered an unauthorized reinsurer, it had trust deposits totaling $134,640,399, $136,825,212 and $123,615,507 as of December 31, 2010, 2009 and 2008, respectively, which represents more than the balance required to back the ceded reserve credits taken by the Company.

Effective January 1, 2006 and through December 31, 2008, the Company was a party to affiliate excess reinsurance agreements with Health Net of New Jersey, Inc., Health Net of Arizona, Inc., and Health Net Health Plan of Oregon, Inc. There was no activity related to these reinsurance agreements in 2010, however in 2009, the Company had assumed claims expense favorable adjustments of $778,536. In 2008, there were assumed premiums of $20,089,727, and assumed claims expenses of $19,488,006.

The Company is included in the consolidated federal income tax returns of HNI. Under a written agreement, HNI collects from, or refunds to its subsidiaries, the amount of taxes or benefits determined as if the subsidiaries filed separate returns. Inter-company tax balances are settled monthly.

22. Additional information required per Guidance 1163:2. Provide the following per Section A of the Guidance for: Health Net, its California health business, and the Individual medical block in California regulated by the Department.

a. For 2008, 2009 and 2010: the post-tax statutory net income, statutory capital and surplus, and RBC authorized control level according to the Annual Statement of Health Net.
b. The anticipated post-tax statutory net income, statutory capital and surplus, and RBC authorized control level anticipated for the company in 2011.
c. The company's dividend history, if applicable

Response: See Table below

Health Net Life Insurance Company	December 31 2008	December 31 2009	December 31 2010	December 31 2011
	(in thousands of dollars)			Forecast
Capital & Surplus	368,802	383,551	414,490	320,784
RBC RATIO - Authorized Control Level	630.21%	675.61%	911.30%	696.41%
- Company Action Level	315.10%	337.81%	455.65%	348.21%
Net income (YTD)	14,086	58,165	26,868	294
Capital contributions	130,000			
Dividends in thousands		35,000		94,000

23. Additional information required per Guidance 1163:2. Provide the following per Section A of the Guidance: The annual compensation of each of the 10 most highly paid executives of both the insurer submitting the rate filing and the parent corporation / ultimate controlling party of that insurer.

Response: See Table below

Health Net of California

	BAS Dollars	BON Dollars	Other Dollars	Total Dollars
Chief Executive Officer 1	$1,200,000.05	$4,878,018.76	$59,283.96	$6,137,302.77
Executive Officer 2	$719,788.43	$1,699,596.47	$29,234.88	$2,448,619.78
Executive Officer 3	$147,900.00	$634,511.09	$802,378.56	$1,584,789.65
Executive Officer 4	$445,369.12	$560,654.72	$16,490.64	$1,022,514.48
Executive Officer 5	$565,548.06	$436,200.00	$8,872.32	$1,010,620.38
Executive Officer 6	$400,000.04	$536,112.98	$17,389.08	$953,502.10
Executive Officer 7	$422,392.74	$430,762.51	$18,978.20	$872,133.45
Executive Officer 8	$409,705.08	$406,442.94	$15,159.00	$831,307.02
Executive Officer 9	$408,484.16	$394,661.24	$1,020.00	$804,165.40
Executive Officer 10	$408,076.92	$381,028.13	$6,281.04	$795,386.09

Health Net Life Insurance Company

	BAS Dollars	BON Dollars	Other Dollars	Total Dollars
Employee 1	$249,708.08	$139,390.44	$29,234.88	$418,333.40
Employee 2	$101,682.89	$27,611.07	$2,944.26	$132,238.22
Employee 3	$99,466.77	$9,830.58	$6,378.00	$115,675.35
Employee 4	$87,222.80	$8,249.65	$9,196.32	$104,668.77
Employee 5	$51,380.61	$34,301.46	$3,062.41	$88,744.48
Employee 6	$72,123.15	$3,312.74	$8,735.84	$84,171.73
Employee 7	$53,868.72	$0.00	$7,278.00	$61,146.72
Employee 8	$48,724.52	$0.00	$2,535.68	$51,260.20
Employee 9	$45,806.52	$0.00	$4,234.91	$50,041.43
Employee 10	$43,032.48	$0.00	$6,578.64	$49,611.12